U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 23 August 2005

In the Matter of:

TOMMY R. DAVIS,
Claimant

Case No.: 2003-BLA-5459

v.

RIVER BASIN COAL CO.,
Employer

and

AMERICAN MINING INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ron Carson, Lay Representative
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

Natalee A. Gilmore, Esq.
Jackson & Kelly
Lexington, Kentucky
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant alleges that he is totally disabled due to pneumoconiosis.

I conducted a hearing on this claim on January 13, 2004, in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") at 13. Director's Exhibits ("DX") 1-36A, Claimant's Exhibits ("CX") 1-5 and Employer's Exhibits ("EX") 1-9 were admitted into evidence without objection. Tr. at 7, 8, and 12. Employer's Exhibits 10-12, as well as Dr. Spitz's x-ray interpretation at Director's Exhibit 16, were excluded because they exceeded the limitations for the submission of evidence contained in the regulations and the Employer failed to show good cause for their admission.[1] Tr. at 12. Moreover, the Employer stated that it will not rely Dr. Hudson's interpretation of the x-ray underlying his report; rather, the Employer will rely on Dr. Wiot's interpretation of the same study. TR 10. The Claimant and Employer submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on July 23, 1999. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on September 3, 1999, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The Claimant did not appeal that determination. DX 1.

More than one year later, the Claimant filed a subsequent claim. DX 3. On November 14, 2002, the District Director issued an *Award of Benefits – Responsible Operator* wherein he concluded that Key Mining Company was a successor operator to Rivers Basin Coal Company. DX 29. The District Director further concluded that Claimant established entitlement to benefits and the award was augmented by reason of his wife, Sandra, as well as the miner's adult disabled daughter, Teresa. The District Director also found that the Miner established 21 years and eight months of coal mine employment.

[1] The Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-69, 1-74 (2004).

On November 18, 2002, the Employer filed a "Request for Hearing and Request for Revision" alleging that the District Director improperly awarded benefits in this claim. DX 31. On December 13, 2002, the District Director issued an "Initial Determination" reaffirming the award of benefits and stating that the claim would be forwarded to the Office of Administrative Law Judges (OALJ) for adjudication. DX 32.

On February 14, 2003, the claim was referred to the OALJ for hearing. DX 36.

APPLICABLE STANDARDS

This claim relates to a "subsequent" claim filed on August 6, 2001. Because the claim at issue was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2005). Pursuant to 20 CFR § 725.309(d) (2005), in order to establish that he is entitled to benefits, the Claimant must demonstrate that "one of the applicable conditions of entitlement … has changed since the date upon which the order denying the prior claim became final" such that he now meets the requirements for entitlement to benefits under 20 CFR Part 718. In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2005). I must consider the new evidence and determine whether the Claimant has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

ISSUES

The issues contested by the Employer are:

1. How long the Claimant worked as a miner.[2]

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

5. Whether his disability is due to pneumoconiosis.

6. The number of his dependents for purposes of augmentation.[3]

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[2] The Claimant alleges 26 years of coal mine employment. The District Director, on the other hand, concluded that there was 21 years and eight months of "verifiable" coal mine employment. DX 36. The Employer agreed to 21 years. Tr. at 5.

DX 36. The Employer, in its Pre-Hearing Report dated December 17, 2003, did not list as contested: (1) its designation as the Responsible Operator; or (2) whether the Claimant has met the threshold requirements of § 725.309 in this subsequent claim. At hearing, the Employer confirmed that the District Director, OWCP, properly identified Key Mining, Inc./Kline Coal as the successor to River Basin Coal Company. Tr. at 5-6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified that he was 64 years old at the time of the hearing and stood 5 feet 8 inches tall. TR 14. His last coal mine employment was in 1991, where he worked for Key Mining for six months. DX 14. For eight years prior to that time, the Claimant worked for Rivers Basin Coal in Tennessee.[4] TR 15. As the Claimant last engaged in coal mine employment in Tennessee, this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc).

The Miner testified that his last coal mining job was as a "face boss." TR 15. He stated that the job required that he check equipment but his "main objective as a face boss was to run coal." TR 15. He testified that, at times, he had to lift 50 pound bags of rock dust and he would "have to pull a motor out." TR 16. The Miner could not recall the weight of the motors. TR 16. The Claimant further stated the following with regard to his job duties:

> You're all the time on the move. You're all the time – you have to check your equipment, you know, stay around you're – make sure you're equipment is going. Like I say, you lift the rock dust and you have bolts, sometimes you help the bolt man load his bolt machine down. You're all the time on the go. You have to check places . . . make sure you're top is pretty good, or hope it's good.

TR 16. The Claimant also recalled that he had to crawl, depending on the "height of the coal." TR 17. The Miner was laid off in 1991 and "[c]ouldn't find no more employment." TR 17.[5]

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[3] The alleged dependents are the Claimant's wife, Sandra, and his adult disabled daughter, Teresa. DX 36. The Employer wished to hear the Claimant's testimony on this issue. Tr. at 5.

[4] In a statement dated June 8, 1992 on West Coal Corporation letterhead, Payroll Clerk Wanda Jeffers confirmed that the Claimant worked for Rivers Basin Coal, Incorporated from September 26, 1989 until June 14, 1991. DX 7.

[5] On September 21, 2001, the District Director received the Miner's "Description of Coal Mine Work and Other Employment." DX 5. In this statement, the Miner noted that, as "face boss," he "was over 10 to 12 men" and had to make "sure the machinery was in good working order." He would stand for eight hours a day, crawl one-quarter to three-quarters of a mile a day, and carry 50 pounds for 50 to 200 feet three or four times a day. Moreover, his job required lifting five to 50 pounds three to five times a day. DX 5.

Turning to his medical condition, the Claimant testified that he has arthritis and trouble breathing. TR 17. He first noticed his breathing difficulties in the "late eighties." TR 17. He stated that "when you bend over to tie your shoe or your boot it was hard when you raise up to breathe." TR 18. He stated that he could not return to his last coal mine employment as a "face boss" because he does not have the "physical ability" to do it. TR 20. The Miner testified that, before the hearing, he became "tired two or three times" walking from the car in the parking lot to the courtroom. TR 20. He states that he can possibly walk three blocks on level ground without becoming short of breath. TR 20. The Claimant has been receiving Social Security disability benefits since 1993 or 1994 for arthritis. TR 22.

The Claimant testified that he is currently being treated by Dr. Baker. TR 18. He no longer seeks treatment from Dr. Hughes:

> I quit Dr. Hughes, Dr. Hughes wasn't helping me. He kept putting me on medicine every month and nothing was helping me. Then I went to see him once there and he told me, he said, if you don't stay on your medicine . . . you ain't going to get no help. I seen I was in trouble, because he was the man taking me off the medicine that he was putting me on.

TR 18-19. The Claimant was hospitalized for a couple of days two years ago because the physician "thought I might have had a light heart attack." TR 23. Other than his prescription inhalers, the Claimant takes a vitamin and an aspirin each day. TR 23-24.

The Claimant is married to Sandra. TR 21.[6] He also has an adult disabled daughter, Teresa, who lives with him and is dependent on him for support. TR 21. He notes that Teresa has cerebral palsy. TR 21.[7]

The Miner stated that he smoked one pack of cigarettes per day starting at the age of 18 years and quitting about eight years prior to the hearing. TR 25.

Length of Employment

According to the employment histories the Claimant submitted to the Department of Labor and Social Security records, the Claimant began working in the mines in 1965. DX4 and 8. He left the mines in 1991. TR 14; DX 8. Based on his Social Security earnings records, the Claimant had the following reported earnings:

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[6] The record contains a *Certificate of Marriage* from the State of Tennessee providing that the Claimant married Sandra in 1966. DX 11.

[7] A psychological evaluation report dated March 17, 1998 by Dr. Virginia Frye is in the record. DX 13. Dr. Frye's report contains a notation that Teresa was diagnosed with cerebral palsy by the age of 1 year and that, at the time of the examination, Teresa was 29 years old and lived with her parents. DX 13.

1965	Hurricane Mountain Coal	$804.48	(Oct-Dec only)
1966		$5,798.41	
1967		$6,041.32	
1968		$5,566.10	
1969		$6,131.33	
1970		$6,215.31	
1971		$6,705.82	
1972		$2,454.33	(Jan-June only)
Total: 6 years and 3 quarters			
1972	Volunteer Mining Corporation	$4,660.70	(July-Dec only)
1973		$9,025.44	
1974		$12,083.71	
1975		$14,100.00	
1976		$15,157.50	
1977		$11,576.09	(Jan-Sept only)
Total: 5 years and 1 quarter			
1977	Dan Branch Mining Company	$3,784.58	(Oct-Dec only)
1978		$17,700.00	
Total: 1 year and 1 quarter			
1979	Rainbow Mining Company	$22,543.91	
1980		$25,900.00	
1981		$27,318.27	
1982		$27,701.07	
1983		$12,038.12	(Jan-Sept only)
Total: 4 years 3 quarters			
1983	Cage Creek Coal Company	$5,687.75	(Oct-Dec only)
1984		$24,012.50	(Jan-Sept only)
Total: 1 year			
1984	Rivers Basin Coal Company	$5,217.50	(Oct-Dec only)
1985		$30,064.63	
1986		$28,740.07	
1987		$26,893.55	
1988		$26,806.61	
1989		$26,043.41[8]	
1990		$26,276.29	
1991		$12,500.00	(Jan-Jun only)
Total: 6 years 3 quarters			

[8] The Miner's records also show employment at Stoney Ridge Coal Company in 1989 where he earned a total of $2,629.31. DX 8.

1991 Key Mining Incorporated $13,125.00 (July-Dec only)
Total: 1 quarter

The Form CM-911a, which was completed by the Miner and submitted on August 6, 2001, reflects an employment history consistent with that documented in the Social Security records. DX 4. There was no testimony at the hearing contradicting the foregoing history of coal mine employment, or providing any reasonable basis to find that the Claimant did not work full-time for the various mining companies. Based on the Miner's testimony and documentary evidence of record, I find that he has established 26 years of coal mine employment. *Clayton v. Pyro Mining Co.*, 7 B.L.R. 1-551 (1984) (any reasonable method of computing length of coal mine employment, which is supported by substantial evidence of record as a whole, will be upheld).

Responsible Operator

After review of the Miner's employment records, the District Director determined that Key Mining Company, as successor operator to Rivers Basin Coal, Incorporated, would be liable for the payment of any benefits awarded in this claim. DX 29. In particular, the District Director stated:

> Mr. Davis' coal mine employment history is documented by his Social Security earnings record and a company statement from West Coal Corporation. These documents indicate that the miner's last coal mine employer was Key Mining, Inc., for whom he worked for a period of less than one year in 1991. Immediately prior to his work for Key Mining, Mr. Davis worked for Rivers Basin Coal, Inc. a subsidiary of West Coal Corporation, from September 26, 1989 to June 1991, clearly a period of more than one year.
>
> Rivers Basin Coal, Inc. was not insured on Mr. Davis' last day of employment, and it has been determined that neither the company nor any of its corporate officers are financially capable of assuming liability for this claim. However, records maintained by the U.S. Department of Labor establish that Key Mining, Inc. and/or Kline Coal Company are successor operators to Rivers Basin Coal, Inc. and were insured by American Mining Insurance Company.
>
> Key Mining, Inc./Kline Coal as Successor to Rivers Basin Coal, Inc. has been designated as the responsible mine operator in this case. Their insurer, American Mining Insurance Company, will be considered liable for the payment of any benefits to which Mr. Davis may be found entitled.

DX 29.

By letter dated December 23, 2003, the Director, OWCP objected to "any effort to put the liability issues back in controversion" at the hearing in this claim. In support of her position, the Director attached a letter dated December 16, 2003 from Martin Hall, counsel for Key Mining, wherein he stated, in part, the following:

> Please accept this letter as Key Mining, Inc.'s response to the Director's Request for Admissions . . .. Based upon the documentary evidence presently of record, Key Mining, Inc. agrees that it is the responsible operator liable for the payment of black lung benefits in this claim if benefits are awarded.

In its Pre-Hearing Report dated December 17, 2003, Employer did not contest the issue of its designation as the responsible operator. Employer offered no further argument on this issue at the hearing or in its closing brief.

At the hearing, the Claimant testified that he last worked for six months in 1991 for Key Mining. TR 15. Prior to that time, he worked for Rivers Basin Coal for eight years. TR 15. As previously noted, the District Director found that Key Mining was a successor operator to Rivers Basin and no evidence has been offered to contradict this finding. DX 29.

The Claimant's testimony is consistent with the District Director's findings which, in turn, are based on the Claimant's Social Security records and a statement from West Coal Corporation. Thus, the evidence of record supports a finding that Key Mining, as successor of Rivers Basin Coal and as insured by American Mining Insurance Company, is liable for the payment of any benefits in this claim. *See* 20 CFR §§ 725.491, 492 and 493 (2005).

Material Change in Conditions

In a subsequent claim, the threshold issue is whether one of the applicable conditions of entitlement has changed since the previous claim was denied. The Miner's previous claim was denied by the District Director on September 3, 1999 for failure to demonstrate any element of entitlement, and the denial became final one year later. According to his testimony, he stopped working in 1991 because of arthritis and breathing difficulties. The first determination must be whether the Claimant has established, with new evidence, that he is totally disabled from pneumoconiosis or other pulmonary or respiratory impairment significantly related to or aggravated by dust exposure. Absent a finding that he suffers from such an impairment, none of the elements previously decided against him can be established, and his claim must fail, because a living miner cannot be entitled to black lung benefits unless he is totally disabled based on pulmonary or respiratory impairments stemming from coal dust exposure. Non-respiratory and non-pulmonary impairments are irrelevant to establishing total disability for the purpose of entitlement to black lung benefits. 20 CFR § 718.204(a) (2005); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994); *Beatty v. Danri Corp*., 16 B.L.R. 1-11, 1-15 (1991), *aff'd*. 49 F.3d 993 (3d Cir. 1995). As will be discussed in detail below, the medical evidence filed in connection with his current claim demonstrates that the Claimant suffers from a totally disabling respiratory impairment, but it does not establish that the Claimant has pneumoconiosis.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in connection with the current claim.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH) or the registry of physicians' specialties maintained by the American Board of Medical Specialties. [9] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

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[9]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07-02-01		EX 2 Wiot B, BCR Completely negative	DX 17 Hughes none Mild hyperinflation of the lung. Occasional calcified granulomas.
09-12-01	DX 14 Baker B 1/0	DX 15 Wiot B, BCR Completely negative; no evidence of coal workers' pneumoconiosis	DX 14 Sargent B, BCR Film is quality 2 (read for quality purposes only)
10-21-01			DX 16 Cohen BCR No ILO classification provided. Stated that study was "essentially normal" with no change since 08-04-99.
10-26-01			DX 18 Barron unknown "Normal wall motion"; "no ischemia"
01-21-02	CX 2 Miller B, BCR 1/1	DX 16 Dahhan B "No coal workers' pneumoconiosis"	
02-26-02	DX 17 Cappiello B, BCR 1/2, p/p all lung zones (note: film quality 3 due to "significant overexposure") DX 17 Alexander B, BCR 1/1, p/q	EX 4 Wiot B, BCR Completely negative	

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
03-10-03	CX 6 Pathak B 1/1	EX 5 Wiot B, BCR Completely negative	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 16 07-02-01 Hughes	62 68"	1.43	2.60	55%	--	Yes	Suboptimal effort exhibited.
DX 14[10] 09-12-01 Baker	62 67"[11]	1.32	3.54	37%	46	Yes	Cooperation was fair and comprehension was good.

[10] Dr. Michos invalidated the ventilatory study by report dated October 18, 2001. DX 14. He noted that there was "excessive variation in peak flows" and "suboptimal MVV performance." He recommended that another test be conducted.

[11] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 66.5" to 68", I have taken the mid-point (67.25") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 14[12] 12-17-01 Baker (retest)	62 67”	1.35	3.56	38%	--	Yes	Cooperation was fair and comprehension was good.
DX 16 Hughes 01-03-02	62 68”	1.16	2.44	47%	--	Yes	
DX 16 Dahhan 01-24-02	62 66.5”	0.96 1.25	1.88 2.49	51% 50%	28 41	Yes Yes	Good cooperation and comprehension.
DX 17 Hughes 03-25-02	63 68”	1.10	2.47	44%	--	Yes	Good cooperation and comprehension.
CX 3 02-26-03 Smiddy	64 68”	1.20	3.37	36%	--	Yes	Good cooperation and comprehension.
CX 4 03-04-03 Narayanan	64 68”	0.84	2.76	30%	--	Yes	Good cooperation and comprehension.
EX 3 Hudson 03-10-03	64 68”	1.11	2.24	49%	--	Yes	

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with the current claim. A “qualifying” arterial blood gas study yields values that are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2005).

[12] Dr. Michos validated this study by report dated January 19, 2002. DX 14.

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?
DX 14	09-21-01	Baker	43	76	No
DX 16	07-02-01	Hughes	42.2	80.1	No
DX 16	01-24-02	Dahhan	45.1 45.4	75.4 80.4	No No
EX 3	03-10-03	Hudson	46.8	78	No

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains the following medical opinions relating to submitted in connection with the current claim.

Treatment and hospitalization records

Evidence in this claim includes numerous treatment and hospitalization records dating from March 1992 through January 2002. DX 16 and 17; EX 1 and 6. Treatment notes from Dr. John Burrell dating March 1992 through September 1999 contain diagnoses of bronchitis, sinusitis, and chronic obstructive pulmonary disease. During a visit on February 15, 1994, Dr. Burrell noted that the Claimant requested nicotine patches to help him stop smoking. Dr. Burrell reported that the Claimant had smoked one and one-half a pack of cigarettes per day for 40 years, but that he quit for six months at one point in time. During a visit on December 12, 1997, Dr. Burrell stated that the Claimant complained that he suffers from shortness of breath "most of the time." On September 16, 1999, Dr. Burrell opined that the miner "does have some severe (chronic obstructive pulmonary disease), past history of coal miner." DX 16.

Dr. Fred Barry treated the Miner on December 17, 1997 for complaints of chest pain and shortness of breath. DX 16. He reported that the Claimant noted a "dull, aching sensation in the chest" at rest and with exercise. Dr. Barry stated that the chest pain could be cardiac or non-cardiac in origin. Lungs were clear on examination and the Miner's EKG results were normal. DX 16.

Dr. Gregory P. LeMense of Horizons Physicians Group treated the miner on September 8, 1999. DX 16; EX 6. Dr. LeMense reported complaints of progressive shortness of breath over the past six months, particularly on exertion. He further stated that the Miner complained of wheezing at times that resolved with rest. The Claimant also reported an increased daily productive cough. Dr. LeMense noted a 35 to 40 year history of smoking one pack of cigarettes per day as well as 25 years of underground coal mining. Examination of the lungs revealed an increased AP diameter as well as "decreased breath sounds throughout with prolonged expiratory phase." Cardiac examination demonstrated a "regular rate and rhythm without murmur, rub, or gallop." Ventilatory testing yielded evidence of "severe obstructive lung disease." Dr. LeMense stated the following:

> Flow volume loop and volume time plotting shows a suboptimal expiratory effort with discontinuation of expiration after five seconds despite continued flow. This would likely artificially reduce the FVC but not FEV1, and may suggest that the FVC is actually larger than 47%. Based on spirometry alone, I cannot rule out the possibility of restrictive lung disease.

A chest x-ray was suggestive of chronic bronchitis, but Dr. LeMense found that "[t]he interstitial markings are not prominent and I see no evidence for coal workers' pneumoconiosis." Dr. LeMense diagnosed progressive dyspnea, particularly on exertion, as well as a daily chronic productive cough. He noted that the Miner "has a heavy smoking history and his spirometry is most consistent with obstructive lung disease." Dr. LeMense opined that the Claimant suffers from "severe chronic obstructive bronchitis and may have a component of emphysema as well." He stated that, although the Miner has a long history of coal mine employement, there was no radiographic evidence to support a diagnosis of coal workers' pneumoconiosis. Based on a lack of x-ray findings as well as the "marked improvement in post-bronchodilator spirometry," Dr. LeMense concluded that "an inhaled steroid is warranted" and, if the Miner does not smoke, "he is likely to have stable lung function." DX 16; EX 6.

In a follow-up visit on November 16, 1999, Dr. LeMense stated the following with regard to the Claimant's condition:

> (The Claimant) notes slight improvement in his dyspnea on exertion, stating that he is able to ambulate further before stopping to catch his breath. He also notes some decrease in the amount of wheezing. He denies significant cough and has had no hemoptysis.

EX 6. Examination of the lungs revealed "decreased breath sounds" and examination of the heart produced normal findings. Dr. LeMense diagnosed chronic obstructive pulmonary disease that "has responded somewhat to Pulmicort plus Combivent." Dr. LeMense reiterated that the

miner "also has a long history of coal dust exposure and I would be somewhat concerned about coal workers' pneumoconiosis, although this was not supported by prior chest radiograph." Rather, Dr. LeMense opined that the Claimant's "main respiratory problem appears to be obstructive lung disease due to his tobacco use." EX 6.

Dr. A. David Slutzker, also with Horizons Physicians Group, examined the Claimant during an office visit on November 28, 2000. DX 16; EX 6. He noted the Miner's history of severe obstructive pulmonary disease. Examination of the lungs revealed an "increased anterior posterior diameter and a prolonged expiratory phase." Cardiac examination yielded evidence of a "[r]egular rate and rhythm with distant heart tones." Dr. Slutzker diagnosed severe obstructive pulmonary disease and a past history of tobacco abuse. DX 16; EX 6.

The Miner was hospitalized from October 21, 2001 to October 22, 2001. DX 16. In the discharge notes prepared by Dr. Harjeet Narula, the following was noted:

> EKG the next morning showed normal sinus rhythm, nonspecific anterior lateral T wave abnormalities. No acute changes. Cardiac enzymes were negative . . .. He had no recurrent chest pain but complained of a headache and was given Vicodin.

DX 16. The record contains treatment notes from Dr. Narula dating from June 2001 through November 2001. DX 17; EX 1. In notes dating October 2001, Dr. Narula reported normal cardiac testing, normal EKG results, and a normal chest x-ray, with no change since August 4, 1999. At various times, Dr. Narula diagnosed chronic obstructive pulmonary disease, allergic rhinitis, and sinusitis among other conditions. DX 17; EX 1.

Dr. Narula referred the Claimant to Dr. Joseph Smiddy for a consultative pulmonary evaluation. CX 3. On February 26, 2003, Dr. Smiddy examined and tested the Miner and issued a report. He reported 26 years of coal mine employment as well as the fact that "[t]he patient previously smoked but quit at age 55." Examination of the lungs revealed "[d]ecreased breath sounds." Cardiac examination did not yield any abnormal findings. Dr. Smiddy noted that an October 21, 2001 x-ray study was reviewed and had been found "normal." Ventilatory testing produced qualifying values. Dr. Smiddy diagnosed chronic bronchitis, chronic obstructive pulmonary disease, and coal workers' pneumoconiosis "with a long history of heavy coal dust exposure." Dr. Smiddy opined that the Claimant "has profound obstructive lung disease which would be (of) as sufficient degree to create 100% total and permanent respiratory disability." CX 3. Dr. Smiddy is board-certified in internal medicine and board-eligible in pulmonary diseases. CX 3.

Dr. R. Hal Hughes also treated the Miner. DX 16. His July 2001 and January 2002 notes are in the record. During the initial evaluation on July 2, 2001, Dr. Hughes noted 26 years of coal mine employment as well as the fact that the Claimant was a "former heavy smoker up until the age of 56." Dr. Hughes reported that the Miner smoked one pack of cigarettes per day from the ages of 17 to 56 years. He noted complaints of increasing dyspnea. Examination of the lungs revealed "[s]lightly decreased breath sounds, but are clear to auscultation." Cardiac examination yielded findings of "[r]egular rate and rhythm without a definite murmur, gallop or

rub." A chest x-ray demonstrated hyperinflated lung fields. Blood gas testing produced non-qualifying results. Dr. Hughes diagnosed a moderate airflow obstruction with a normal diffusion capacity consistent with chronic bronchitis and asthma. He opined that "[g]iven (the Miner's) smoking history, emphysema with a bronchospastic component cannot be entirely excluded." He further reported the presence of an "obstructive physiology" with significant exposure to coal dust, but without definite radiographic evidence of coal workers' pneumoconiosis. Dr. Hughes further stated that the Miner had "atypical" chest discomfort that was possibly related to "GE reflux." DX 16.

During a follow-up visit on January 3, 2002, Dr. Hughes noted that the Miner complained of "chronic dyspnea." DX 16. Examination of the lungs revealed that they were "clear to auscultation with decreased breath sounds." Ventilatory testing produced values that were decreased from those obtained in July of 2001. Dr. Hughes diagnosed a moderate to severe airflow obstruction with normal diffusion capacity consistent with chronic bronchitis or asthma. Pleural plaques present on the chest x-ray were indicative of asbestos exposure and the Miner had atypical chest discomfort, but his cardiac testing was negative. DX 16.

Dr. Glen Baker

Dr. Glen Baker examined and tested the Claimant on behalf of the Department and issued a report on September 12, 2001. DX 14. He reported 25 to 26 years of coal mine employment, where the Miner last worked as a "face boss" in 1991. Dr. Baker further noted that the Claimant smoked one pack of cigarettes per day from 18 to 56 years of age for a total of 38 years. Dr. Baker noted complaints of arthritis in the Miner's legs and back since 1991 as well as "attacks of wheezing" and chronic bronchitis over the past five years. Dr. Baker also recorded the following additional complaints of daily sputum production, dyspnea after walking one-quarter of a mile on level ground, coughing, substernal chest pain of unknown etiology, difficulty sleeping, some wheezing, and "occasional shortness of breath." Examination of the lungs revealed decreased breath sounds. A chest x-ray was interpreted by Dr. Baker as revealing Category 1 pneumoconiosis. Ventilatory testing yielded evidence of a "mild obstructive defect." Blood gas testing demonstrated the presence of "mild resting arterial hypoxemia." An EKG showed "normal sinus rhythm." Dr. Baker diagnosed coal workers' pneumoconiosis based on a positive chest x-ray interpretation and the Miner's employment history. He further concluded that, based on ventilatory testing, the Claimant suffered from chronic obstructive pulmonary disease due to his smoking and coal mining histories. Dr. Baker also found that the Miner's hypoxemia on blood gas testing was due to coal mining and smoking histories. Finally, Dr. Baker opined that the Claimant suffered from artherosclerotic heart disease of unknown etiology based on complaints of chest pain. Dr. Baker concluded that the Miner suffered from a moderate level of impairment due to smoking and coal workers' pneumoconiosis. He further stated that the Claimant could not perform the work of a coal miner because his FEV1 was at 44 percent. DX 14.

Dr. Baker subsequently became the Miner's treating physician and issued he has issued a supplemental letter dated July 19, 2003 in support of this claim for benefits. CX 1. In the letter, Dr. Baker reviewed the testing conducted as part of the September 2001 evaluation and stated the following:

> In summary, I do feel the patient has a respiratory problem based on his symptoms and pulmonary function studies. His impairment could be at least in part due to coal dust. I think his x-ray shows evidence of Coal Workers' Pneumoconiosis, Category 1/0, on basis of 1980 ILO Classification. I have seen the patient for approximately two months and I have treated him for a breathing impairment with Atrovent and Pulmicort inhalers. The patient does have a moderately severe to severe breathing impairment and this has decreased his activity of daily living.

CX 1. Dr. Baker noted that the Miner's "breathing test(s) are, at least, some improved," but did not further explain his conclusions in light of this observation. CX 1.

Dr. Baker is board-certified in internal medicine and pulmonary diseases and a Fellow of the American College of Chest Physicians. He is also a B-reader. CX 1.

Dr. A. Dahhan

Dr. A. Dahhan examined and tested the Miner, reviewed certain medical records, and issued a report at the request of the Employer on January 24, 2002. DX 16. Dr. Dahhan noted a 40 year history of smoking one pack of cigarettes per day (from the ages of 17 to 57 years). He further reported 25 years of coal mine employment. Dr. Dahhan found that the Miner complained of a daily productive cough and intermittent wheezing as well as "dyspnea on exertion such as a flight of stairs." Examination of the lungs revealed an increased AP diameter of the chest and "[a]uscultation revealed prolongation of the expiratory phase with scattered expiratory phase." Cardiac examination produced findings of "regular rhythm with normal heart sounds." Blood gas testing at rest yielded non-qualifying values. Ventilatory testing produced evidence of "moderately severe obstructive ventilatory defect with partial response after the administration of bronchodilator therapy." Diffusing capacity was at 38 percent of predicted and, after correction for alveolar volume, it was 78 percent of predicted. A chest x-ray was interpreted as revealing Category 0 pneumoconiosis. Dr. Dahhan concluded that there was insufficient objective data to support a finding of coal workers' pneumoconiosis. He cited to the obstructive abnormalities on ventilatory testing responded significantly after use of a bronchodilator, normal blood gas testing before and after exercise, and a negative chest x-ray reading in support of his opinion. Dr. Dahhan opined that the miner suffered from a totally disabling respiratory impairment due to his obstructive airway disease, but it was unrelated to coal dust exposure due to the fact that the Claimant quit working in 1991 and ventilatory testing revealed a significant bronchodilator response. On the other hand, Dr. Dahhan concluded that the Miner's airway disease is caused by his lengthy smoking habit. DX 16.

Dr. Dahhan was deposed on December 29, 2003. EX 8. He noted that he is presently engaged in private practice:

> The majority of my practice is patient care. The type of patient and problems that are seen by me are medical problems with the bulk of them being pulmonary

> conditions, and since I have been in practice for many years I have a good deal of pulmonary-type practice that has accumulated.

EX 8 at 7.

Dr. Dahhan explained some of the findings made on his examination of the Miner. He stated that an increased AP diameter means that "the chest cavity was larger than it should be." EX 8 at 10. Increased resonancy to percussion indicates "an excessive amount of air in the thorax." EX 8 at 10. The Miner's prolonged expiratory phase meant that "it took a longer time for the air to come out on exhalation." EX 8 at 10. Expiratory wheezing was indicative of "tightness in the bronchial pipes." EX 8 at 10. Dr. Dahhan stated the following with regard to the Claimant's ventilatory test results:

> Overall, the spirometry indicated severe obstructive ventilatory impairment with significant response to bronchodilator therapy. The lung volume measurements indicated the presence of an obstructive pattern as well as the diffusion capacity.

EX 8 at 14. Dr. Dahhan concluded that the Miner's totally disabling obstructive impairment was due to his smoking history as well as, possibly, to bronchial asthma or hyperactive airways disease based on the inhaler medications prescribed for him and the significant response to bronchodilator therapy during testing. EX 8 at 15 and 17.

Dr. Dahhan is board-certified in internal medicine and pulmonary medicine. He is also a B-reader. DX 16; EX 8 at 4.

Nurse Kellie Brooks

Nurse Kellie Brooks, of Stone Mountain Health Services, examined and tested the Claimant at his request and issued reports on March 28, 2002 and April 2, 2002. DX 17. Ms. Brooks has a Master's of Science in Nursing, where she graduated from the University of Virginia in May 1999 with a Grade Point Average of 4.0. DX17; CX 5. She is certified as a Family Nurse Practitioner by the American Nurses Credentialing Center. CX 5.

In the March and April 2002 reports, Nurse Brooks noted that the Claimant had 27 years of coal mine employment, but she did not note his smoking history. DX 17. She stated that the Miner complained of shortness of breath on exertion, such as walking on level ground for less than 100 feet. Ventilatory testing revealed a severe obstruction. A chest x-ray was interpreted by Dr. Alexander, a dually-qualified physician, as revealing Category 1 pneumoconiosis. Nurse Brooks diagnosed the presence of coal workers' pneumoconiosis by chest x-ray as well as chronic obstructive pulmonary disease. She concluded that the Claimant's "respiratory abnormalities and shortness of breath are directly related to his coal mining history and coal dust exposure." DX 17.

On April 14, 2003, Nurse Brooks reported that the Claimant was examined as part of his "health maintenance visit." CX 5. Nurse Brooks noted complaints of increased shortness of breath as well as a daily productive cough and "3 pillow orthopnea." She stated that "[i]t is of

note that (the Miner) stopped smoking in 1995 after smoking one pack per day for 35 years." Examination of the lungs revealed a "barrel chest," "[d]iminished breath sounds in all fields," and bilateral crackles at the lung bases. Cardiac examination was "distant due to his barrel chest," but no abnormal findings were reported. Nurse Brooks diagnosed coal workers' pneumoconiosis with no further explanation.

Nurse Brooks was deposed on September 29, 2003. EX 7. She has served as a Family Nurse Practitioner at Stone Mountain Health since June of 1999. EX 7 at 3. On a daily basis, Nurse Brooks testified that:

> I provide medical care from histories, physicals, manage chronic conditions, acute care, prevention. I do family practice, geriatric, pediatric, women's health and I've been working with the Black Lung Program for four years.

EX 7 at 3-4. Nurse Brooks estimated that she has treated 750 to 800 black lung patients while at Stone Mountain Health. EX 7 at 12. She attended the University of Virginia to receive her Master's degree in Nursing. EX 7 at 4-5. Nurse Brooks is supervised by Dr. Art VanZee, who is a board-certified physician in internal medicine at Stone Mountain Health, "He does not have patients, but I consult with him for my patients." EX 7 at 5-6.

Nurse Brooks examined the Miner on two occasions and stated the following with regard to the Black Lung Program:

> As part of our Black Lung grant they have to come in. And what we do is we . . . go through their medicines, occupational history, history and physical and do an exam. They come in and they get the breathing test, a chest x-ray and then they see me. And then I do follow-up too, I see them in follow-up.

EX 7 at 7. She noted that the miner had a 35 year history of smoking one pack of cigarettes per day, where he quit in 1995. EX 7 at 10.

Dr. Arnold Hudson

Dr. Arnold Hudson examined and tested the Miner, reviewed certain medical records, and issued a report on March 10, 2003 at the request of the Employer. EX 3. Dr. Hudson reported 26 years of coal mine employment as well as a 35 to 45 year history of smoking one pack of cigarettes per day. He noted that the Miner complained of a chronic cough with occasional production of brown sputum as well as dyspnea. Dr. Hudson stated that the Miner "estimates he can walk 300 to 400 feet on level ground without stopping." The Claimant's past medical history included "recurrent chronic bronchitis, chest pain, and arthritis among other conditions. Examination of the lungs revealed "unlabored" respirations as well as a slight increase in resonance to percussion. There were decreased breath sounds bilaterally with increased expiratory time and no rales or wheezes. Cardiac examination yielded findings of a "[r]egular rhythm (with) no gallop or murmur." Blood gas testing produced non-qualifying results. Dr. Hudson stated that the ventilatory testing demonstrated "very severe airway obstruction with a reduced forced vital capacity" and the diffusion capacity was "borderline low

normal." Although Dr. Hudson noted a two to three centimeter opacity on a chest x-ray, he did not find that it was related to coal dust exposure and concluded that the chest x-ray revealed Category 0 pneumoconiosis.[13] Dr. Hudson diagnosed chronic obstructive bronchitis and emphysema secondary to cigarette smoking as well as a history of undefined arthritis and certain other conditions. He concluded that the Miner was totally disabled due to cigarette-smoke induced chronic obstructive pulmonary disease. Dr. Hudson opined that he did not "find any evidence that (the Claimant) has significant lung disease as a consequence of his previous coal mining." Dr. Hudson provided no further discussion or explanation of his conclusions. EX 3.

Dr. Hudson was deposed on December 30, 2003. EX 9. During the deposition, Dr. Hudson reiterated his findings on examination. EX 9 at 8-9. He concluded that the Miner suffered from a "disabling chronic obstructive pulmonary disease," but did not suffer from legal or clinical coal workers' pneumoconiosis. EX 9 at 11. Dr. Hudson stated that the Claimant has a:

> . . . very significant smoking history, which would adequately explain the cause of his lung disease. Also, he doesn't give any exposure history in his mining career of some severe overwhelming fume exposure that may have caused reactive airway disease.

EX 9 at 12. He further noted that the Miner experienced "some improvement in his air flow after inhalation of a bronchodilator." EX 9 at 12. Dr. Hudson reiterated that the Miner is totally disabled due to a smoking-induced respiratory impairment. EX 9 at 12.

Dr. Hudson is board-certified in internal medicine and pulmonary diseases. He is also a board-certified medical examiner. He has engaged in practice through the Knoxville Pulmonary Group from 1976 to present. EX 3; EX 9 at 4-5.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust

[13] At the hearing, the Employer withdrew Dr. Hudson's interpretation of the study and replaced it with Dr. Wiot's interpretation. Because Dr. Wiot found that the study was "completely negative," it is determined that Dr. Hudson's opinion is not adversely affected by reliance on his inadmissible x-ray interpretation.

exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, the Claimant's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease, bronchitis, and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion.

There is no evidence that the Miner has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions applies, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993).

As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The x-ray study dated July 2, 2001 was interpreted as completely negative by Dr. Wiot, a dually-qualified physician. Dr. Hughes, who has no specialized radiological qualifications, noted hyperinflation of the lungs, but he did not provide a specific ILO classification. Based on Dr. Wiot's superior qualifications, and because he specifically concluded that the study was completely negative, the study does not support a finding of pneumoconiosis.

The September 2001 study was interpreted by Dr. Baker, a B-reader, as demonstrating Category 1 pneumoconiosis. Dr. Wiot, on the other hand, determined that the study was completely negative. Given Dr. Wiot's superior radiological qualifications, his opinion is entitled to greater weight and the study does not support a finding of pneumoconiosis.

A study dated October 22, 2001 was reviewed by Dr. Cohen, a board-certified radiologist, and he found that the study was "essentially normal." Similarly, Dr. Barron did not provide a specific reading for pneumoconiosis with regard to the October 26, 2001 study. As Drs. Cohen and Barron did not provide an ILO classification of the study as required by § 718.102(b) of the regulations, the studies do not constitute probative evidence of the presence or absence of pneumoconiosis.

A January 2002 study was interpreted by Dr. Miller, a dually-qualified physician, as positive for the presence of pneumoconiosis. Dr. Dahhan, a B-reader, found that the study was negative. On balance, the study supports a finding of pneumoconiosis due to Dr. Miller's superior qualifications.

The February 2002 study was interpreted by Drs. Alexander and Cappiello, dually-qualified physicians, as demonstrating Category 1 pneumoconiosis. They did note that the film was overexposed. Dr. Wiot concluded that the same study was completely negative. Given that a majority of the dually-qualified physicians concluded that pneumoconiosis was present, this study supports a finding of pneumoconiosis.

However, a study conducted more than one year later, on March 10, 2003, was interpreted by Dr. Wiot as completely negative. Dr. Pathak, a B-reader, concluded that the study revealed Category 1 pneumoconiosis. On balance, Dr. Wiot possesses superior radiological qualifications and, as a result, his negative interpretation is accorded greater weight.

Given the contemporaneous nature of the February 2002 and March 2003 films and the fact that physicians providing conflicting interpretations of the films are dually-qualified, I do not find that either film ultimately provides a credible basis upon which to find the presence or absence of pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to the Claimant's subsequent claim. The Miner cannot be found to have pneumoconiosis on the basis of the x-ray evidence. Some studies do not provide credible evidence of the presence or absence of pneumoconiosis due to conflicting interpretations of the studies by equally qualified physicians or the physicians' failure to provide an ILO classification. On the other hand, while the January and February 2002 study supported a finding of pneumoconiosis, the July 2001, September 2001, and March 2003 studies produced preponderantly negative findings. Of note, I accord greatest weight to Dr. Wiot's interpretation on two grounds. First, he was the only radiologist to review films spanning a two year period of time, which afforded him a more comprehensive view of any changes that occurred. Second, Dr. Wiot helped to develop the ILO classification system and has superior expertise in the area of interpreting x-ray studies for the presence or absence of pneumoconiosis. Weighing the x-ray evidence as a whole, I find that the Miner has not sustained his burden of demonstrating pneumoconiosis by a preponderance of the evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

Of the medical professionals who examined the miner in conjunction with this subsequent claim, Dr. Baker and Nurse Brooks diagnose the presence of clinical and legal coal workers' pneumoconiosis. Drs. Dahhan and Hudson, on the other hand, conclude that the miner suffers from neither condition; rather, they opine that the Claimant's respiratory impairment is smoking-induced.

A medical opinion better supported by the objective medical evidence of record is entitled to more weight. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n.1 (1986).

On this basis, I accord greater weight to the opinions of Drs. Dahhan and Hudson that the Miner does not suffer from clinical pneumoconiosis. Their reports are better in accord with my findings of the chest x-ray evidence of record, which preponderantly produced either equivocal or negative results.

Turning to the diagnosis of legal coal workers' pneumoconiosis, Drs. Baker, Dahhan, and Hudson as well as Nurse Brooks agree that the Claimant suffers from chronic obstructive pulmonary disease. Some of these experts also diagnose chronic bronchitis, emphysema, and/or asthma. Dr. Baker attributed development of the Claimant's obstructive lung disease to his coal mining and smoking histories. However, he failed to explain his causation diagnosis and, as a result, I find his report less probative. *See Clark, supra.*

Similarly, Nurse Brooks diagnosed the presence of coal dust induced lung disease, but she also failed to explain her causation findings. Therefore, her report is entitled to less weight on the issue. *See Clark, supra.*

On the other hand, Drs. Dahhan and Hudson did explain why the miner's respiratory impairments were unrelated to his history of coal dust exposure. Among the factors cited, both physicians noted that the Claimant's ventilatory test results exhibited improvement after use of a bronchodilator. They properly opine that this is inconsistent with an irreversible disease process such a coal workers' pneumoconiosis. Importantly, Dr. Baker also noted some improvement in the miner's breathing tests, but he did not explain his diagnosis of coal workers' pneumoconiosis in light of this observation. *See Crace, supra.*

Dr. Dahhan further cited to the Miner's non-qualifying blood gas study results as evidence that the Miner suffers from a non-coal-dust-related impairment. This is consistent with the Board's holding in *Morgan v. Bethlehem Steel Corp.*, 7 B.L.R. 1-226 (1984). In *Morgan*, the Board concluded that, although blood gas studies are relevant primarily to a determination of the existence or extent of an impairment, such evidence "also may bear upon the existence of pneumoconiosis insofar as test results indicate the absence of any disease process, and by implication, the absence of any disease arising out of coal mine employment." In this case, all of the Claimant's blood gas testing yielded non-qualifying results which, as noted by Dr. Dahhan, further supports a finding that the Claimant does not suffer from a coal-dust-induced disease.

On balance, Drs. Dahhan and Hudson are board-certified in internal medicine and pulmonary diseases and, most importantly, their reports are well-documented and better reasoned than the contrary opinions of Dr. Baker and Nurse Brooks. In addition, the opinions of Drs. Dahhan and Hudson are supported by the opinions of the Miner's treating physicians. Specifically, physicians from Horizons Physicians Group, Drs. LeMense and Slutzker, examined and tested the Miner and concluded that his respiratory impairments were most likely the result of his past tobacco abuse. Dr. LeMense found no evidence of clinical pneumoconiosis based on a lack of chest x-ray findings, which is consistent with my findings based on the x-ray evidence of record. Moreover, as with Drs. Dahhan and Hudson, Dr. LeMense noted that the "marked improvement in post-bronchodilator spirometry" militated against a finding that the Claimant's severe obstructive lung disease, bronchitis, and emphysema stem from his long-term tobacco

use. Another treating physician, Dr. Hughes, also indicated that there was a causal connection between the Miner's lung impairments and his history of smoking cigarettes.[14]

Notably, the only medical evidence submitted in conjunction with the Miner's original claim was the report and testing for the Department of Labor sponsored examination as required at 20 C.F.R. § 725.406 (2005). DX 1. In that report dated August 4, 1999, Dr. Lee J. Seargeant, Jr. concluded that the Miner did not suffer from any coal-dust-induced lung disease. DX 1. An x-ray study underlying the report was interpreted as demonstrating "no evidence of pneumoconiosis" by Dr. Cohen and as "completely negative" by Dr. E.N. Sargent.

In the final analysis, I find that the Claimant has not established pneumoconiosis on the basis of medical opinion evidence submitted in connection with his initial claim, or based on the new evidence submitted to support his subsequent claim. Neither the x-ray evidence, nor the medical opinion evidence, weighed separately or together, is sufficient to establish the existence of pneumoconiosis. Nor has the Claimant shown its presence by any other means. I find that the Claimant has failed to meet his burden of showing that he has a pulmonary or respiratory disease attributable to his exposure to coal dust. Thus, he cannot show that he is entitled to benefits under the Act.

Total Pulmonary or Respiratory Disability

As noted above, the Sixth Circuit standard for review of a subsequent claim requires that the entire record be considered if a claimant establishes one of the elements of entitlement previously decided against him. Although I have ultimately decided that the evidence as a whole does not establish that has pneumoconiosis, I have reviewed the entire record, rather than just the new evidence, because the new evidence does establish that he is totally disabled by a pulmonary impairment.

The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Miner suffers from complicated pneumoconiosis or cor

[14] Notably, Dr. Smiddy served as a consultant for one of the Claimant's treating physicians. Dr. Smiddy diagnosed the presence of coal workers' pneumoconiosis, but failed to provide any reasoning for this opinion. This is particularly problematic where Dr. Smiddy noted that the chest x-ray reviewed was normal. In support of his diagnosis, Dr. Smiddy merely cited to "a long history of heavy coal dust exposure." In *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000), the court held that diagnosing coal workers' pneumoconiosis based on a chest x-ray and coal mine employment history does not constitute a "well reasoned" opinion. Because Dr. Smiddy failed to explain his diagnosis in light of the "normal" chest x-ray and lack of findings, his opinion is not probative of the existence of pneumoconiosis.

pulmonale. Thus, I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

None of the newly submitted blood gas studies yielded qualifying results. Moreover, blood gas testing conducted in conjunction with the Miner's original claim also produced non-qualifying results. The Miner has not demonstrated a totally disabling respiratory impairment under § 718.204(b)(2)(iv) of the regulations.

On the other hand, all of the newly submitted ventilatory studies produced qualifying results. Moreover, the August 4, 1999 pulmonary function study results of FEV1 equal to 1.03 and FVC equal to 1.89 submitted with the original claim are qualifying. The Claimant has demonstrated that he suffers from a totally disabling respiratory impairment under § 718.204(b)(2)(i) of the regulations.

In addition, all physicians and Nurse Brooks, who issued reports addressing the extent of the Miner's disability in this subsequent claim, conclude that he suffers from a totally disabling respiratory impairment. I agree, based on the Claimant's testimony as well as the medical evidence of record, that he is totally disabled. Specifically, the Claimant's last coal mining job required occasionally lifting 50 pound bags of rock dust and motors of unspecified weight as well as being "all the time on the go." His job also required crawling inside the mine. It is evident that the Miner engaged in heavy manual labor and the moderate to severe obstructive lung disease diagnosed by the physicians and Nurse Brooks would render him unable to perform his last coal mining job. Moreover, when these opinions are considered in conjunction with the results of the objective tests, *i.e.* qualifying pulmonary function study testing, I conclude that the Claimant suffers from a totally disabling respiratory impairment.

Although the Claimant has demonstrated that he is now totally disabled from a respiratory standpoint, he has not established that he suffers from coal workers' pneumoconiosis and, thus, his disability cannot be due to the disease. Consequently, benefits must be denied.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he is totally disabled due to coal workers' pneumoconiosis, he is not entitled to benefits under the Act.

REPRESENTATIVE'S FEES

The award of a representative's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C.

§ 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Tommy R. Davis on August 6, 2001, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).